STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 01 B. WING	05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN 46573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/22/12 Facility Number: 000521 Provider Number: 155582 AIM Number: 100266980 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detectors in the resident rooms. The facility has a capacity of 133 and had a census of 117 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/25/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 3 of 14 service area corridor doors protecting corridor openings. This deficient practice could affect any residents in the Beauty Shop, the Executive Director's office and the Assistant Director of Nursing (ADON) office. Findings include: Based on observation with the Maintenance Supervisor 05/22/12 from 1:50 p.m. to 3:00 p.m., the corridor doors to the Beauty Shop, the ADON's office and the Executive Director's office were equipped with a kick down door	K0018	The kick down door stops were removed from the Beauty Shop, ADON Office & Executive Director doors by 5/24/12. No residents were affected by this deficiency. Any residents located in the Beauty Shop, ADON Office, or Executive Director's office could have been affected by this deficiency. An all staff inservice was conducted on 6/7/12 to remind staff to not prop any facility door for any reason at any time. A Quality Assurance Tool (Attachment A) will be used 3 times per week for 4 weeks, then 1 time per week thereafter, to ensure that office doors are not propped ongoing. The Maintenance Supervisor, or designee, will be responsible.	06/21/2012

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	stop. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)			

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 kitchen corridor doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect any in the main dining room. Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 at 2:30 p.m., both corridor doors leading into the kitchen were equipped with kick down door stops. This was acknowledged by the Maintenance Supervisor at the time of	K0021	The kick down door stops located on the 2 kitchen corridor doors were removed by 5/24/12. The rubber door wedges located at the single fire doors leading to the Assisted Living Facility were removed on 5/22/12. No residents were affected by this deficiency. Any residents located in the main dining room or rehab unit could have been affected by this deficiency. A quote was obtained by Safe Care (Attachment B) to add 2 magnetic door holds to the 2 kitchen corridor doors so that these doors will remain open unless our fire system is activated, which would then release the doors to close automatically in the event of a fire. An all staff inservice was conducted on 6/7/12 to remind staff to not prop any facility door for any reason at any time. A Quality Assurance Tool	06/21/2012

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	observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 horizontal exit single fire doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect any residents evacuated through the Rehabilitation hall exit in the event of a fire emergency. Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 at 1:40 p.m., both single fire doors leading to the Assisted Living building were propped open with a rubber door wedge. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		(Attachment A) will be used 3 times per week for 4 weeks, then 1 time per week thereafter, to ensure that the kitchen & exit doors leading to the Assisted Living Facility are not propped ongoing. The Maintenance Supervisor, or designee, will be responsible.	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect any resident without a medical diagnoses requiring security measures exiting through the Rehabilitation and Maintenance Hall exits.	K0038	Codes were posted at the Rehabilitation Hall & Maintenance Hall exit doors by 5/25/12. No residents were affected by this deficiency. Any resident trying to exit the facility at the Rehabilitation Hall & Maintenance Hall exit doors could have been affected by this deficiency. An all staff inservice was conducted on 6/7/12 to inform staff that codes were now posted at the Rehabilitation Hall & Maintenance Hall exit doors. No further corrective action or monitoring will be necessary as this solution will permanently resolve this issue in its entirety.The spare wheelchairs were removed from the Maintenance Shop Exit Corridor by 5/23/12. The 2 hand carts were moved down the hall towards the dining room by 5/23/12 to not interfere with the exit located within the Maintenance Shop Corridor. No residents were affected by this deficiency. Any residents being evacuated through the Maintenance Shop Corridor Exit could have been affected by this deficiency. An all staff inservice was conducted on 6/7/12 to remind staff to not place any wheelchairs, or other items, in the Maintenance Shop Corridor at any time in the future and to keep	06/21/2012

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	Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 during the tour from 1:35 p.m. to 1:45 p.m., the Rehabilitation Hall and the Maintenance Hall exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. The Maintenance Supervisor stated he was not aware of this requirement. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure egress for 1 of 5 exit corridors was not used for storage. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects any resident evacuated through the maintenance shop corridor.		the hand carts located in their current position ongoing. A Quality Assurance Tool (Attachment A) will be used 3 times per week for 4 weeks, then 1 time per week thereafter, to ensure that the no wheelchairs, or other items, & hand carts are in their proper location ongoing. The Maintenance Supervisor, or designee, will be responsible.	

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	Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 at 1:10 p.m., the egress path in the maintenance shop exit corridor was used for storage of spare wheelchairs and two hand carts. Based on an interview with the Maintenance Supervisor at the time of observation, he said this was the permanent storage area for spare wheel chairs. 3.1-(19)			

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K0048 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the use of the K-Class fire extinguisher in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect any residents and staff in and near the kitchen in the event of an emergency. Findings include: Based on a record review with the Maintenance Supervisor on	K0048	We believe that it is important to note that the facility did provide a written plan that included the use of the K-Class fire extinguisher & copies were present in the Station 2 Nurses Station & Maintenance Supervisor's Disaster Manuals upon inspection on 5/22/12. Furthermore, the facility does acknowledge that there was not a copy of this policy located in the Executive Director's Disaster Manual upon inspection on 5/22/12. No residents were affected by this deficiency. Any residents located near the kitchen during an emergency could have been affected by this deficiency. A copy of the written plan including the use of the K-Class fire extinguisher was placed in the Executive Director's Disaster Manual by 5/23/12 (Attachment C). The Executive Director will be responsible to ensure that this policy remains in the Executive Director's copy of the Disaster Manual ongoing & this manual will be reviewed on an annual basis.	06/21/2012

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	05/22/12 at 12:18 p.m., the "Disaster Manual" did not address the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Maintenance Supervisor at the time of record review, this was the copy of the Disaster Manual from the Executive Director's office. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 electrical/water heater/sprinkler riser rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. This deficient practice could affect any residents near the Station 1 nurses' station. Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 at 2:22 p.m., the electrical/water heater/sprinkler	K0056	On 6/5/12, Safe Care removed & sealed off 1 of the 3 sprinker heads located in the Inservice Director's office, thus eliminating the concern with having 2 of the 3 sprinkler heads located 30 inches apart or within 6 feet of each other (Attachment D). Furthermore, on 6/5/12, Safe Care added 2 sprinker heads in the electrical/water heater/sprinkler riser room, thus eliminating the concern with not having an automatic sprinkler system in this room (Attachment D). No residents were affected by this deficiency. Any residents located in the Inservice Director's office or near the Station 1 Nurses Station could have been affected in the event of a fire emergency related to this deficiency. No further corrective action or monitoring will be necessary as this solution will permanently resolve this issue in	06/21/2012

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	riser room lacked sprinkler coverage. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 3 sprinkler heads in the Inservice Director's office were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident in the Inservice Director's office in the event of a fire emergency. Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 at 2:00 p.m., two of three sprinkler heads in the Inservice Director's office were located thirty inches apart. This was acknowledged by the Maintenance Supervisor at the time of observation.		its entirety.	

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K0072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure no furnishings, decorations or other objects were placed as to obstruct exits for 1 of 9 exits. This deficient practice could affect any occupants evacuated through the main dining room exit in the event of an emergency. Findings include: Based on observation with the Maintenance Supervisor on 05/22/12 at 1:20 p.m., the exterior exit discharge path for the main dining room exit is obstructed by lawn furniture. Based on an interview with the Maintenance Supervisor at the time of observation, the main dining room exit discharge path was obstructed by two metal chairs and a metal bench. 3.1-19(b)	K0072	No residents were affected by this deficiency. Any residents being evacuated through the main dining room exit in the event of an emergency had the potential to be affected by this deficiency. The Maintenance Supervisor removed the lawn furniture obstructing the exterior exit discharge path for the main dining room on 5/22/12. An all staff inservice was conducted on 6/7/12 to remind staff to not block facility exits or exterior sidewalks at any time in the future. A quote from Huff Construction (Attachment E) was obtained to install an additional 5' x 23' patch of concrete leading directly from the main dining room exit discharge path to the parking lot located at the rear of the facility, which will bypass the area where the lawn furniture is normally located. A Quality Assurance Tool (Attachment A) will be used 3 times per week for 4 weeks, then 1 time per week thereafter, to ensure that the exterior exit discharge path for the main dining room is not obstructed by any objects in the future. The Maintenance Supervisor, or designee, will be responsible.	06/21/2012

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K0076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen cylinders in the Station 2 medication room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any staff in or near the Station 2 medication room. Findings include: Based on an observation with the Maintenance Supervisor on 05/22/12 at 1:05 p.m., there was an unsupported "E" cylinder of compressed oxygen in the Station	K0076	The E cylinder oxygen tank was removed from the Station 2 Medication Room on 5/22/12 by the Maintenance Supervisor. No residents were affected by this deficiency. Any resident located near the Station 2 Medication Room could have been potentially affected by this deficiency. An all staff inservice was conducted on 6/7/12 to remind nursing staff to not store any E cylinder oxygen tanks in the Station 2 Medication Room & to only store them in the proper location ongoing. A Quality Assurance Tool (Attachment A) will be used 3 times per week for 4 weeks, then 1 time per week thereafter, to ensure that E cylinder oxygen tanks are not stored in the Station 2 Medication Room ongoing. The Maintenance Supervisor, or designee, will be responsible.	06/21/2012

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	155582	A. BUILDING 01 B. WING	05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN 46573

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	2 medication room. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			

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K0154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to protect 117 of 117 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance	K0154	We believe that is important to note that the facility did provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system were to be out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1 as copies were present in the Station 2 Nurses Station & Maintenance Supervisor's Disaster Manuals upon inspection on 5/22/12. Furthermore, the facility does acknowlege that there was not a copy of this policy located in the Executive Director's Disaster Manual. No residents were affected by this deficiency. All facility residents had the potential to be affected by this deficiency. A copy of the written plan for our "Fire Watch" policy (Attachment F), along with a "Fire Watch Log" (Attachment G), was added to the Executive Director's copy of the Disaster Manual on 5/24/12. The Executive Director will be responsible to ensure that this policy remains in the Executive Director's copy of the Disaster Manual ongoing & this manual will	06/21/2012

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	155582	A. BUILDING 01 B. WING	05/22/2012

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MILLER'S MERRY MANOR	300 N WASHINGTON ST WAKARUSA, IN 46573

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	carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Watch Policy and Procedure" policy with the Maintenance Supervisor on 05/22/12 at 12:22 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not address the following: a) the designated person(s) shall be trained b) the local fire department must be notified Based on interview with the Maintenance Supervisor at the time of record review, it was acknowledged the Executive Director's fire watch policy did not include the aforementioned items.		be reviewed on an annual basis.	

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	3.1-19(b)			

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K0155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 117 of 117 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3	K0155	We believe that is important to note that the facility did provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system were to be out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1 as copies were present in the Station 2 Nurses Station & Maintenance Supervisor's Disaster Manuals upon inspection on 5/22/12. Furthermore, the facility does acknowlege that there was not a copy of this policy located in the Executive Director's Disaster Manual. No residents were affected by this deficiency. All facility residents had the potential to be affected by this deficiency. A copy of the written plan for our "Fire Watch" policy (Attachment F), along with a "Fire Watch Log" (Attachment G), was added to the Executive Director's copy of the Disaster Manual on 5/24/12. The Executive Director will be responsible to ensure that this policy remains in the Executive Director's copy of the Disaster Manual ongoing & this manual will	06/21/2012

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	requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants. Findings include: Based on review of the "Fire Watch Policy and Procedure" policy with the Maintenance Supervisor on 05/22/12 at 12:22 p.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but it did not address the following: a) the designated person(s) shall be trained b) the local fire department must be notified Based on interview with the Maintenance Supervisor at the time of record review, it was acknowledged the Executive Director's fire watch policy did not include the aforementioned items. 3.1-19(b)		be reviewed on an annual basis.	